PRINTED: 11/27/2007
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	R 11/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	4515 EDSON PLACE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS A follow-up survey was conducted from November 14, 2007 through November 16, 2007, to determine the facility's compliance with previous condition level deficiencies cited on October 5, 2007. Clients #2 and #5 were randomly selected from the five clients originally sampled in October. Clients #6 and #7 were then added to the sample. In addition, focused reviews were conducted in follow-up to the October 5, 2007 survey, as follows: - Client #1's mealtime protocol, nutritional intake, repositioning and adaptive equipment needs; - Client #3's active treatment, physical therapy and adaptive equipment needs; and, - Client #4's active treatment, mealtime protocol and ambulation/ physical therapy programs. The findings of this survey were based on observations, interviews with direct support and administrative staff in the home and at a day program serving three of the sampled clients, and the review of records, including incident reports and administrative records. The survey findings determined that the facility was in substantial compliance with all federal conditions of participation; however, standard-level deficiencies remained, as documented in the report that follows.	{W 000}		
{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by:	{W 104}	W104	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Branch | TITLE: ORS | (X6) DATE: 12-6-07

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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{W 104}	Continued From page 1 Based on staff interview and record review, the governing body failed to ensure timely implementation of its policy on adaptive equipment: acquisition, replacement, modification and repair, for two of the eight clients residing in the facility. (Clients #1 and #3) The findings include: 1. Cross-refer to W436. Interview with the Qualified Mental Retardation Professional on November 14, 2007, at approximately 3:00 PM, revealed the agency had established guidelines for timely acquisition, replacement, modification and repair of adaptive equipment. According to the adaptive equipment policy: "acquisition, repair, modification, or replacement of adaptive equipment shall occur within sixty days of the date from when the need was determined. While there are circumstances beyond the control of the provider and or DDS that impact compliance with this timeline, such as delays in insurance approvals, every effort should be made to meet or exceed this timeline and to follow-up with the party responsible for the delay." There was no evidence, however, that the governing body actively monitored the implementation of this policy to ensure timely repair and/or replacement of wheelchairs for Clients #1 and #3. 2. Cross-refer to W159.2. There was no evidence that the governing body had monitored the clients' adaptive equipment needs, to ensure that the facility purchased and/or utilized properly clients' transfer slings and/or wedge for positioning while in bed.	{W 104}	W104, Continued This Standard will be met as evidenced by: (1) Cross reference response to W436.	12.19.07 ongoing
			(2) Cross reference response to W159.2	12.19.07
W 111	483.410(c)(1) CLIENT RECORDS	W 111		

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W 111	Continued From page 2 The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on interview and record review, facility nurses failed to update client records as indicated, for one of the six clients in the sample. (Client #4) The findings include: 1. Nursing supervisors failed to provide oversight to ensure accuracy of client records, as evidenced by the following: On November 15, 2007, at approximately 12:30 PM, review of Client #4's Nursing Progress Notes revealed that on November 10, 2007, 8:30 AM, a nurse wrote the following: "slight pink area on right hand. No pain noted. Area cleaned with normal saline...PCP made aware." Subsequent review of the Staff Daily Progress Notes in Client #4's record revealed nothing unusual was documented on November 9, 2007. There was no daily progress note from a direct support staff for the morning of Saturday, November 10, 2007. At 1:08 PM, the "day nurse" was asked about the nurse's progress note and she stated that she was previously unaware of any "pink areas" discovered on Client #4. She did, however, state that the client had receive a flu shot on November 9, 2007. Initially, this was being treated as if it were an injury of unknown origin. However, telephone	W 111	W111 This Standard will be met as evidenced by: (1.) Nursing supervisor will continue to provide oversight and review of client #4's record. LPN staff will receive additional training as needed to further ensure that documentation and information is accurate, and reflects the actual experience.	12.18.07 ongoing

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W 111	Continued From page 3 interview with the LPN who had made the entry, at 1:16 PM, revealed that the nurse had indeed seen the pink area on the "upper arm, near the shoulder," in the location where the client had received a flu shot. Further interview revealed that he had not been aware that the client had received a flu shot on the day before. The flu shot, however, had been documented in the same Nursing Progress Notes, on November 9, 2007. During the aforementioned interviews, the day nurse indicated that the error of writing "right hand" instead of indicating the upper arm was a common error in certain immigrant populations. However, the Director of Nursing had stated over the telephone that the hand and upper arm "are too far apart to get confused." Further review of Client #4's medical chart failed to show evidence that supervisory nursing staff had reviewed Client #4's progress notes to ensure accuracy. 2. Nursing staff failed to update/ revise Client #4's HMCP, to reflect a change in the client's physical therapy programs and/or prescribed treatment for pain. a. On November 15, 2007, review of Client #4's Health Management Care Plan (HMCP), dated September 24, 2007, revealed "potential for pain due to DJD;" though not spelled out, DJD stands for degenerative joint disease. The HMCP indicated that staff were to provide the client range of motion (ROM) exercises and to monitor for signs of pain. However, review of the client's updated Individual Support Plan (ISP), dated October 5, 2007, revealed that his physical therapist and interdisciplinary team had changed the programs and the client now was to ambulate	W 111	W111, Continued... (2) Reference response to W111 #1. (a) QMRP will review and discuss program objective with the Physical Therapist and/ change or modify as recommended. Client #4's HMCP will be updated as needed to reflect changes.	

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W 111	Continued From page 4 around the home and dance for up to 3 minutes with staff instead of the ROM exercises. The HMCP had not been updated to reflect the new ISP objectives. b. In addition, the HMCP failed to reflect the use of medication for treatment of joint pain. Client #4's physician's orders (POs) dated June 1, 2007 included a handwritten notation dated May 1, 2007 for Tylenol 325 mg x 2 tabs was ordered as needed for pain or temperature greater than 100 degrees. On October 2, 2007, the client was evaluated in a hospital ER after experiencing pain and swelling of his right thigh and foot. The ER discharge summary listed as primary diagnosis "arthritis - degenerative." The primary care physician's SOAP note dated October 4, 2007 did not reflect Tylenol for pain; however, his SOAP note dated October 13, 2007 included "P: Tylenol for joint pain." The October 13, 2007 SOAP note failed to specify the frequency/ parameters for administration of the Tylenol. The most recent physician's orders issued/ printed by the pharmacy, dated September 1, 2007, did not reflect Tylenol. Further review of the client's medical record failed to clarify whether the October 13, 2007 SOAP note was a continuation of Tylenol on an as needed (PRN) basis or whether it represented a change to daily/ routine treatment order. 3. Cross-refer to W252. Staff failed to enter observed behavioral incident data into Client #1's and #4's records, in accordance with behavior programs.	W 111	W111, Continued--- (b) Reference response to W111 #1 and #1.a (3) Cross-reference response to W252.	
{W 120}	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services-	{W 120}	W120	

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{W 120}	Continued From page 5 meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to effectively monitor each client's day program to ensure that the day programs provided services in accordance with interdisciplinary team recommendations, for three of the six clients in the sample. (Clients #2, #5 and #4) The findings include: On November 14, 2007, Clients #2, #5 and #7 were observed at their day program, beginning at 10:36 AM. Although the Qualified Mental Retardation Professional (QMRP) had documented a visit to this day program on October 23, 2007, continued deficiencies were identified, as follows: 1. From 10:40 AM until approximately 11:50 AM, Client #5 was observed seated in the lunch room/ cafeteria. She was seated in her wheelchair, next to a dining table with no materials presented and little to no staff interaction. She was not observed engaged in a meaningful activity throughout the 70-minute period. There were approximately three direct support staff in the cafeteria with more than 15 other clients. At 11:28 AM, review of her Active Treatment Schedule revealed "personal care, implementation of ADL objectives, activity of choice, repositioning" between 9:30 AM - 11:00 AM. The schedule then listed "lunch preparation, choice activities, personal care" from 11:00 AM - 11:30 AM, and she was to have lunch between 11:30 AM - 1:30 PM. Observations revealed Client #5 did not receive continuous	{W 120}	W120, Continued . . . This Standard will be met as evidenced by: (1) QMRP will address observations with the day program staff and develop additional strategies as needed. QMRP will continue to monitor active treatment and program activities and address concerns as they arise.	12.14.07 ongoing

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{W 120}	Continued From page 6 active treatment on the morning of November 14, 2007. 2. At approximately 11:02 AM, the day program coordinator was observed walking in the cafeteria holding Client #5's high sided plate. He was again observed walking to and from the "serving area" of the cafeteria holding her high sided plate, at approximately 11:35 AM. At no time during this period, or while Client #5 ate her lunch (11:52 AM - 12:05 PM), was there a plate guard attached to her plate ,in accordance with her mealtime protocol. 3. At 11:01 AM, direct support staff at the day program stated that Client #5 "eats by herself" and no staff assistance was needed. A few minutes later, interview with the coordinator also indicated that she ate independently. At 11:52 AM, Client #5 was observed eating without staff assistance. She was spooning her food rapidly into her mouth. Staff did not provide her any assistance. At approximately 2:50 PM later that day in the residence, the Director of Nursing described a technique by which staff encourage Client #5 to eat more slowly. They also push some of her food towards the back and side of her plate so that when she scoops her food, less food ends up on the spoon ("a 1/2 a teaspoon instead of heaping"). The QMRP described the same technique during an interview that started at 4:00 PM. She stated that this was the only way staff could intervene without upsetting the client. At 4:33, the QMRP acknowledged that she had not yet shared the information with the day program. During dinner, at approximately 5:25 PM, direct support staff in the home allowed the client to scoop foods without assistance (it was fast, and the spoonfuls heaping). They then	{W 120}	W120 Documentation will be maintained in the client records. 2. Reference response to W120 #1. 3. QMRP will follow-up with day program and provide additional training as needed. Also, reference response to to W120, #1.	

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{W 120}	Continued From page 7 demonstrated the technique of pushing foods to the side and back of plate; the client's pace was better controlled, as intended. 4. At 12:23 PM, Client #2's day program coordinator retrieved her mealtime protocol, dated June 1, 2007, from the cafeteria binder that held protocols for all clients in Client #2's group. The protocol had been developed by the day program nutritionist. However, while this surveyor was leaving the day program, at 12:49 PM, the coordinator presented another mealtime protocol, dated October 15, 2007, which he said he had retrieved from a file in the nurse's office. Interview with the QMRP revealed that she had brought the protocol to the day program on October 23, 2007, which was also documented on the protocol by day program staff initials with date. Comparison of the two protocols revealed differences, as follows: (a) added to the October 15, 2007 protocol was a reminder to "See Program to bring the cup to her mouth with hand-over-hand assistance;" (b) the June 1, 2007 protocol did not reflect the "1 cup of milk, 1 cup of water" served with lunch and "1 cup of water" at PM snack, as indicated on the October 15, 2007 protocol; and (c) the June 1, 2007 protocol did not reflect "Do not give raisin bread" as indicated on the October 15, 2007 protocol. There was no evidence that day program staff were implementing the revised protocol. 5. At 11:18 AM, direct support staff were asked whether Client #2 stayed in her wheelchair all day. She replied no, she was repositioned onto mats either during the morning hours or in the afternoon. She further indicated that another class was using the mats at that time; therefore, Client #2 would be repositioned after lunch. At	{W 120}	W120, Continued... (4.) Reference response to W120 #1-3. (5.) QMRP will follow-up with day program staff and address positioning and adaptive equipment issues. QMRP will also request and/or visit the day program to verify that staff are implementing strategies in accordance to their plans.	12-14-07 ongoing

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{W 120}	Continued From page 8 approximately 12:25 PM, review of the client's Reposition Chart for November 2007 revealed that she was repositioned once per day. Each entry for November indicated that it occurred in the morning and instead of being on mats, the chart indicated "wheelchair tilted" for each day documented. At 12:30 PM, the coordinator was asked about Client #2's repositioning. He stated that he personally repositioned her to a mat during the afternoons. He acknowledged that he was not documenting the afternoon repositioning. On November 15, 2007, at 10:25 AM, the QMRP stated that she had not requested repositioning charts from the day program and had not observed Client #2 being repositioned at the day program. She acknowledged that she had not verified that the client was repositioned at least every two hours, in accordance with her annual plan, dated June 22, 2007. It should be noted that interviews with the QMRP on November 14, 2007, at 9:37 AM and November 15, 2007, at 10:25 AM, revealed that she had not observed either Clients #2 or #5 receiving their lunch meals during her October 23, 2007 visit. She acknowledged that she had not returned to the day program since then to verify that staff were properly implementing their mealtime protocols, including use of adaptive equipment. It should be further noted that during the November 15, 2007, interview, at 10:25 AM, the QMRP acknowledged that she had not sought documentation from the day program or otherwise tried to verify through observation that day program staff were repositioning the five clients at least every two hours, in accordance with their plans.	{W 120}		

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{W 124}	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Surveyor: Dugger, Gayle Based on observation, interview and record verification, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for one of the four clients in the sample. (Client #4) The finding includes: The October 5, 2007 recertification survey had revealed that the facility failed to document having reviewed Client #4's Behavior Support Plan (BSP) with his legal guardian. The BSP incorporated the use of restrictive techniques to manage his behaviors. On November 14, 2007, at approximately 2:45 PM, the Qualified Mental Retardation Professional (QMRP) stated that Client #4's court-appointed guardian had not attended the interdisciplinary team annual ISP meeting on October 5, 2007, which was verified by review of the attendance sheet. The QMRP further stated that she had not telephoned or otherwise had contact with the legal guardian since the October 5, 2007 survey.	{W 124}	W124, Continued ... This Standard will be met as evidenced by: • Reference response to W111 • Reference response to W331.2-3. • QMRP will contact Legal guardian to discuss client #4's Behavior Support Plan and use of restrictive techniques risks/benifits and right to refuse treatment.	12.20.07 ongoing

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{W 124}	Continued From page 10 Cross-refer to W331.2-3. On November 15, 2007, at approximately 3:20 PM, interviews with the QMRP and nursing staff, in conjunction with a review of the client's medical and active treatment records, revealed changes in his willingness to participate in physical therapy programs/ activities. There was no evidence of a comprehensive joint evaluation in the record.	{W 124}		
{W 159}	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate and coordinate each client's active treatment programs, for five of the six clients in the sample. (Clients #1, #2, #3, #5 and #7) The findings include: 1. Cross-refer to W120. The QMRP failed to monitor to ensure that day programs implemented clients' mealtime protocols, as updated on October 15, 2007. 2. The QMRP failed to ensure that transfer sheets were used as recommended for Clients #3, #7 and #2. a. Client #3 was observed seated in his wheelchair on November 14, 2007 at 8:52 AM. The review of Client #3's physical therapy (PT)	{W 159}	W159 This Standard will be met as evidenced by: (1) Cross reference response to W120 (2) QMRP ordered transfer sheets for #3, #7 and #2. (3) QMRP will provide additional staff training as needed and conduct routine observations	12.20.07 ongoing

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{W 124}	Continued From page 10 Cross-refer to W331.2-3. On November 15, 2007, at approximately 3:20 PM, interviews with the QMRP and nursing staff, in conjunction with a review of the client's medical and active treatment records, revealed changes in his willingness to participate in physical therapy programs/ activities. There was no evidence of a comprehensive joint evaluation in the record.	{W 124}		
{W 159}	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate and coordinate each client's active treatment programs, for five of the six clients in the sample. (Clients #1, #2, #3, #5 and #7) The findings include: 1. Cross-refer to W120. The QMRP failed to monitor to ensure that day programs implemented clients' mealtime protocols, as updated on October 15, 2007. 2. The QMRP failed to ensure that transfer sheets were used as recommended for Clients #3, #7 and #2. a. Client #3 was observed seated in his wheelchair on November 14, 2007 at 8:52 AM. The review of Client #3's physical therapy (PT)	{W 159}	W159 This Standard will be met as evidenced by: (1) Cross reference response to W120 (2) QMRP ordered transfer sheets for #3, #7 and #2. (3) QMRP will provide additional staff training as needed and conduct routine observations	12.20.07 ongoing

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{W 159}	Continued From page 11 assessment, dated April 24, 2007, on November 16, 2007 at 2:37 PM revealed a transfer sling was recommended. Interview with direct care staff and observation on November 16, 2007 3:00 PM revealed the transfer sling was in the client ' s bedroom. Interview with the QMRP at 3:15 PM indicated that the transfer sling should be placed underneath the client when he is in his wheelchair. The client was observed returning home from his day program at 3:40 PM on November 16, 2007 without his transfer sling in his wheelchair. b. On November 14, 2007 at 8:20 AM Client #7 was observed seated in her wheelchair. The review of her PT assessment, dated June 16, 2007, revealed a recommendation to purchase a transfer sling. Observation and interview with staff on November 15, 2007 at approximately 2:50 PM revealed the transfer sling was in the client's bedroom. Interview with the QMRP at 2:55 PM revealed the transfer sling should stay with the client to ensure proper lifting. c. On November 14, 2007, at 6:43 PM, the QMRP and a certified nursing assistant were observed transfering Client #2 from her wheelchair into a recliner in the living room. They had some difficulty getting the client, whose records indicated was obese, through the process. On November 15, 2007, at 6:50 PM, the QMRP confirmed that there had been some difficulties in transfering the client. She further indicated that Client #2 was resistive to partuicipating in the transfer process to any degree. At 7:02 PM, review of Client #2's PT assessment, dated June 16, 2007, revealed a recommendation to purchase a "transfer sling" and a "wedge to use with repositioning while in	{W 159}	W159, continued... to further ensure ongoing usage of the trans slings. QMRP will purchase wedge pillow. Reference response to W210 Reference response to W249. Cross reference response to W252.	

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{W 159}	Continued From page 12 bed." At 7:11 PM, observation of the client's bed failed to show evidence of a wedge pillow and there was no transfer sling in the client's wheelchair or in her bedroom. At that time, the QMRP acknowledged that neither the transfer sling nor the wedge pillow had been purchased to meet Client #2's assessed needs. 3. Cross-refer to W210. The QMRP failed to ensure that Client #4 received an updated Occupational Therapy assessment, timely. 4. Cross-refer to W249. The QMRP failed to ensure that all staff were trained to effectively implement Client #2's spout cup (hand-over-hand) training objective. 5. Cross-refer to W252. The QMRP failed to ensure accurate documentation of Client #1's and Client #2's behavioral incidents and Client #3's physical therapy objectives.	{W 159}		
{W 210}	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that assessments had been completed within 30 days after admission by the interdisciplinary team for one of the six clients in the sample. (Client #4) The finding includes:	{W 210}	W210 This Standard will be met as evidenced by: QMRP will follow-up to obtain updated Occupational Therapy Assessment for client #4.	12.22.07 ongoing

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{W 210}	Continued From page 13 On November 15, 2007, interview with the Qualified Mental Retardation Professional (QMRP) revealed that Client #4 remained without a current Occupational Therapy assessment. The most recent assessment was dated September 26, 2006.	{W 210}		
{W 249}	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement programs as outlined in the Individual Program Plans (IPPs), for one of the six clients in the sample. (Client #2) The finding includes: On November 14, 2007, a direct support staff person was observed feeding Client #2 her dinner. After spooning approximately 5 spoonfuls of food, the staff took the client's spout cup and 'dropped' a drop or two of water into the client's mouth, before resuming with the feeding. She repeated the process again and throughout the meal. At no time was the staff observed to offer or encourage the client to place her hand on the spout cup. On November 15, 2007, at 10:12 AM,	{W 249}	W249 This Standard will be met as evidenced by: QMRP/nurse will continue to monitor mealtimes, and provide direction and feedback as needed, to ensure ongoing compliance with this standard.	12-3-07 ongoing

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{W 249}	Continued From page 14 review of the client's IPP revealed a program for Client #2 to "participate in bringing her cup to her mouth to drink when given hand over hand assistance..." Staff were not observed implementing the program as written during dinner on November 14, 2007.	{W 249}		
{W 252}	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to collect data that was reflective of client's performance, for three of the six clients in the sample. (Clients #1, #3 and #4) The findings include: 1. On November 14, 2007, at approximately 7:00 AM, Client #1 was observed displaying inappropriate behavior at the breakfast table. She screamed and tried to grab or strike Client #8 with her hand. Client #1 knocked over a mealtime protocol that was on the table. Direct support staff intervened and when the client did not immediately calm down, they wheeled her into the living room area and away from the other clients. On November 16, 2007, at approximately 3:45 PM, review of the client's behavior support plan (BSP), dated October 5, 2007, revealed that "screaming" and "reaching for/ grabbing others" were both targeted maladaptive behaviors. The BSP instructed staff to document every	{W 252}	W252 This Standard will be met as evidenced by: (1) QMRP will provide additional staff training in this area and provide ongoing monitoring and oversight to ensure that data collection is accurate and reflects individual performance/s. #2, #3, #4 reference response to W 252 #1.	12-13-07 ongoing

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{W 252}	Continued From page 15 occurrence. Review of Client #1's behavior data sheets a few minutes later, however, revealed that staff had not documented the behavioral incident in her record. 2. On November 14, 2007, at 4:55 PM, Client #4 was observed in the front foyer engaged in karaoke activities with direct support staff and the Qualified Mental Retardation Professional (QMRP). At approximately 5:00 PM, the QMRP presented an alphabet puzzle board to him, twice. He rejected the puzzle board and slapped his face a few times. He complied with the QMRP's request that he keep his hands away from his face. At approximately 5:30 PM, Client #4 was observed in the front foyer with a direct support staff person. The client was stimulating himself manually in his genital area. The staff person suggested that he move his hand away, and he complied. On November 16, 2007, at approximately 3:49 PM, review of Client #4's BSP, dated August 19, 2007, revealed that "face slapping" and "public masturbation" were both targeted maladaptive behaviors. The BSP instructed staff to document every occurrence. Review of Client #4's behavior data sheets a few minutes later, however, revealed that staff had not documented the behavioral incident in his record. This is a repeat deficiency. See Federal Deficiency Report, dated October 5, 2007 - Citation W252. 3. Interview with the QMRP at 4:10 PM on November 16, 2007 indicated that Client #3 had a program objective which stated that he "will tolerate stretching to his lower extremities daily for 2 minutes each stretch for 6 months." Further	{W 252}		

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{W 252}	Continued From page 16 review of the instructions for completing the objective revealed that four different stretching exercises should be attempted during each session and that the number of repetitions performed of each exercise should be documented. Additionally, the program instructions revealed that program should be implemented daily and documented daily. Documentation reflected that the objective was implemented daily in October 2007; however the number of repetitions performed was documented only on October 7, 2007. Program data for November 2007 was collected three times a week and the number of repetitions performed was not documented. There was no evidence data was collected in measurable terms. 4. Interview with the QMRP on November 16, 2007 at 4:07 PM revealed that Client #3 had a program goal to improve his static sitting balance which was implemented twice daily. Review of the objective revealed that the client "will sit on the side of his bed for two minutes three times a day." Program data for October 2007 indicated the program was implemented once a day on three days a week. Program data for November 2007 reflected the program was implemented twice daily on November 14, 2007 and 15, 2007 and one time a day on November 2, and November 5, 2007. Interview with the QMRP indicated that the frequency of the program implementation was recommended to be changed from three times a day to two times a day. There was no evidence data was collected in measurable terms. c. Client #4 had a goal to improve his bed -	{W 252}		

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{W 252}	Continued From page 17 mobility. The objective "will roll in bed with maximum assistance from staff using bedrails for 5 repetitions 2 times a day at 100 % accuracy." Instructions reflected that data should be collected two times a day. Record verification revealed that data was collected once a day on 13/31 days in October 2007. Review of November 2007 data revealed data was collected once a day every other day. There was no evidence the data was collected as recommended to monitor the client's performance in the objective.	{W 252}		
{W 263}	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure program which incorporate restrictive techniques and use of behavior modification were conducted only with written informed consent of the client, or legal guardian for one of the four clients in the the sample. (Client #4) The finding includes: There was no evidence of written informed consent for the use of Client #4's Behavior Support Plan, which incorporated the use of restrictive measures. [See W124]	{W 263}	W263 This Standard will be met as evidenced by: Reference response to W124. QMRP will obtain informed consent will be obtained.	12.21.07 ongoing
{W 436}	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed	{W 436}	W436	

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{W 436}	Continued From page 18 choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure that adaptive equipment identified as needed by the interdisciplinary team were furnished and provided for three of one of the six clients residing in the facility. (Clients #1, #3, and #7) The findings include: 1. The facility failed to ensure timely repair of client wheelchairs, as follows: a. On November 14, 2007 at 8:52 AM Client #3 at was observed seated in a wheelchair with his feet resting on the floor and hips not at the rear of chair. Interview with the nurse indicated that a new wheelchair had been ordered for the client. Interview with the QMRP at 9:52 AM revealed the client brought the wheelchair from the nursing home when he was admitted on March 26, 2007. The QMRP indicated that PT evaluated the wheelchair to determine its appropriateness for the client.. The old wheelchair was assessed by the home manager on April 20, 2007 and determined to need the seat bracket secured to the frame and the right brake repaired. The PT conducted a comprehensive assessment on April 20, 2007 and recommended the following repairs:	{W 436}	W436, continued... This Standard will be met as evidenced by: (1) QMRP will continue to follow-up and address wheelchair concerns for client #3. According to previous QMRP, current chair is new. Reference response to W159.	12.2007 ongoing

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{W 436}	Continued From page 19 a) Seat bracket misaligned b) Chest straps loose and ineffective c) Release tabs on armrest damaged d) Right brake damaged e) No anti tippers The PT recommended to repair the old wheelchair and to use it as a backup until a new chair could be obtained. Record review revealed a physical therapy assessment dated April 24, 2007 which recommended a new wheelchair and seating system. A corresponding 719A dated July 9, 2007 for a new wheelchair with custom seating was observed in the clients record. At the time of the survey, the right brake and the release tables on the armrests continued to be damaged. Further interview with the QMRP indicated that the approved 719A for the new wheelchair was forwarded to the vendor, however the vendor had not responded.. There was no evidence Client #1 received timely repair to his wheelchair to ensure that it was maintained in a fully operable good condition until he received his new wheelchair. b. On November 14, 2007 at 8:30 AM, observation of the right wheel of Client #1's wheelchair revealed that it was bent and the tires very worn (chunks of rubber were missing). A large hole was observed on the left side of the seat of the wheelchair. Interview with the QMRP on November 14, 2007 at approximately 9:38 AM revealed repairs had been requested for the wheelchair. Record review revealed an adaptive equipment assessment dated August 9, 2006 as follows: a) Seating system on both old and new chairs is torn b) Broken hydraulics on old chair	{W 436}	W436, Continued... QMRP will coordinate additional staff training as needed.	

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{W 436}	Continued From page 20 c) New tires needed for old chair d) Brakes not engaging properly e) Recommendation for seat repairs for tear. Wheels too old ; chair needs replacement A wheelchair assessment dated June 30, 2007 revealed a need for tire replacement, brake repair, and repair of the seating system. Record review revealed a signed 719A dated July 15, 2007 for repairs on the seating system, replacement of tires and brake repair. A second wheelchair assessment dated August 10, 2007 also documented worn wheels/tires and that the brakes did not lock properly. A 719A dated 8/10/07 for replacement of tires and brake repair was observed in the client's record. The wheelchair vendor's assessment on August 23, 2007 revealed a broken tilt cable, damaged rear wheels (both), no head rest, no chest harness. The broken items on the chair were recommended to be replaced. It was noted on the assessment however that the manufacture of the wheelchair could not be located. Record review revealed an October 2, 2007 physical therapy assessment which stated the client damaged her most recent wheelchair and was using her old custom molded wheelchair. Follow-up on the wheelchair repairs was recommended. The QMRP stated that the client's most recently received wheelchair was not in the facility. The review of Client #1's health management care plan revealed a recommendation that her wheelchair be maintained at all times. There was no evidence, however, that Client #1 received timely repairs to her wheelchair(s) to ensure that they were maintained in good condition.	{W 436}		

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{W 436}	Continued From page 21 2. The facility failed to furnish the recommended knee braces for Clients #3 and #7. a. Interview with the Qualified Mental Retardation Professional (QMRP) on November 15, 2007 at 4:18 PM indicated that Client #3 went on appointment to be assessed for the recommended knee brace at a rehabilitation hospital on October 31, 2007. Further interview with the QMRP revealed the rehabilitation hospital provided pictures of various knee braces from which a selection was made and forwarded to a company able to provide the knee brace. The review of the physical therapy assessment dated April 24, 2007 revealed the knee brace was recommended at that time. There was no evidence the knee brace had obtained for the client. b. On November 14, 2007 at 8:20 AM Client #7 was observed seated in her wheelchair. The review of her physical therapy assessment dated June 16, 2007 revealed a recommendation to purchase knee braces to improve her knee extension range of motion. transfer sling. Interview with direct staff on November 15, 2007 at approximately 2:50 PM indicated that the client did not have knee braces. Interview with the QMRP on November 15, 2007 at 3:18 PM indicated that Client #1 did not have knee braces. There was no evidence the physical therapist's recommendation for knee braces for Client #7 had been addressed. 3. Cross-refer to W159.2. The facility failed to make available and/or utilize properly clients' transfer slings and/or wedge for positioning while in bed.	{W 436}	W436, continued.. QMRP will follow-up with Physical Therapist as needed to ensure that all adaptive equipment needs are met. Knee braces for client #7 will be ordered as recommended. QMRP will maintain documentation to reflect actions taken toward securing all recommended equipment/ equipment repairs. Active Treatment Specialist will continue to document status/condition of wheelchair on a weekly basis.	12.18.07

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{I 000}	INITIAL COMMENTS A follow-up survey was conducted from November 14, 2007 through November 16, 2007. Residents #2 and #5 were randomly selected from the five residents originally sampled in October. Residents #6 and #7 were then added to the sample. In addition, focused reviews were conducted in follow-up to the October 5, 2007 survey, as follows: - Resident #1's mealtime protocol, nutritional intake, repositioning and adaptive equipment needs; - Resident #3's active treatment, physical therapy and adaptive equipment needs; and, - Resident #4's active treatment, mealtime protocol and ambulation/ physical therapy programs. The findings of this survey were based on observations, interviews with direct support and administrative staff in the home and at a day program serving three of the sampled residents, and the review of records, including incident reports and administrative records.	{I 000}		
{I 047}	3502.5 MEAL SERVICE / DINING AREAS Each GHMRP shall be responsible for ensuring that meals, which are served away from the GHMRP, are suited to the dietary needs of residents as indicated in the Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure that meals served away from the GHMRP suited the	{I 047}	1047 3502.5 This Statute will be met as evidenced by:	

Health Regulation Administration

Nancy Branch — TITLE DRS — (X6) DATE 12.6.07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{I 047}	Continued From page 1 residents' dietary needs, for one of the six residents in the sample. (Resident #5) The findings include: On November 14, 2007, Resident #5 was observed at her day program, beginning at 10:36 AM. Although the Qualified Mental Retardation Professional (QMRP) had documented a visit to this day program on October 23, 2007, continued deficiencies were identified, as follows: 1. At approximately 11:02 AM, the day program coordinator was observed walking in the cafeteria holding Resident #5's high sided plate. He was again observed walking to and from the "serving area" of the cafeteria holding her high sided plate, at approximately 11:35 AM. At no time during this period, or while Resident #5 ate her lunch (11:52 AM - 12:05 PM), was there a plate guard attached to her plate, in accordance with her mealtime protocol. At approximately 12:05 PM, the day program coordinator stated that she was to use a plate guard at her meals. 2. At 11:01 AM, direct support staff at the day program stated that Resident #5 "eats by herself" and no staff assistance was needed. A few minutes later, interview with the coordinator also indicated that she ate independently. At 11:52 AM, Resident #5 was observed eating without staff assistance. She was spooning her food rapidly into her mouth. Staff did not provide her any assistance or prompting to slow her pace. At approximately 2:50 PM later that day in the residence, the Director of Nursing described a technique by which staff provide verbal prompting for Resident #5 to eat more slowly. Staff also use a second spoon to push some of her food	{I 047}	Reference response to Federal Deficiency Report W120 and W159.	12.20.07 ongoing

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{I 047}	Continued From page 2 towards the back and side of her plate. Doing os meant that the resident scooped less food into the spoon ("1/2 a teaspoon instead of heaping"). The QMRP described the same technique during an interview that began at 4:00 PM. She stated that this was the only way staff could intervene without upsetting the resident. At 4:33 PM, the QMRP acknowledged that she had not yet shared the information with the day program. It should be noted that interviews with the QMRP on November 14, 2007, at 9:37 AM and November 15, 2007, at 10:25 AM, revealed that she had not observed Resident #5 receiving her lunch meal during her October 23, 2007 visit to the day program. She acknowledged that she had not returned to the day program since then to verify that staff were properly implementing the mealtime protocol, including use of adaptive equipment.	{I 047}		
{I 056}	3502.14 MEAL SERVICE / DINING AREAS Each GHMRP shall train staff in the storage, preparation and serving of food; the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times. This Statute is not met as evidenced by: Based on interview and review of personnel and staff training records, the GHMRP failed to ensure that a certified food handler was available on site during the preparation and serving of every meal. The finding includes: On November 15, 2007, at approximately 10:30 AM, the QMRP indicated that she was unsure	{I 056}	(I056) 3502.14 This Statute will be met as evidenced by:	

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{I 056}	Continued From page 3 about which staff had current food handler's certifications. She sought documentation from the corporate office. Review of the personnel information that was sent from the office later that day, at approximately 4:10 PM, revealed no evidence that the GHMRP ensured that a certified food handler was on duty for meal preparation and service at every shift. The only individual with a current food handler's certification was the House Manager. Personnel records indicated that 11 out of 12 direct support staff were without current food handler's certification.	{I 056}	Direct Support staff will be scheduled to attend the next food handlers certification. Training Manager will continue to monitor and track staff compliance and provide feedback as needed.	12.28.07 ongoing
{I 206}	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.	{I 206}	(I206) 3509.6 This Statute will be met as evidenced by:	
	This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to show evidence of a current health certification/inventory for all personnel. The findings include: Review of personnel information made available during the revisit, on November 15, 2007, at approximately 2:00 PM, revealed no evidence of a current health certification/inventory for the following individuals working with the residents: - 1 of the 12 direct support staff (S1), and		Current health certificate will be obtained for one nurse and the social worker.	12.18.07

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{I 206}	Continued From page 4 - 1 of the 10 nurses (N1) - the social worker	{I 206}	(1206) Human Resources and Admin. Assistant will continue to monitor on a regular basis request information as needed.	
{I 291}	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to update resident records as indicated, for two of the six residents in the sample. (Residents #1 and #4) The findings include: 1. Nursing supervisors failed to provide oversight to ensure accuracy of Resident #4's medical records, as follows: On November 15, 2007, at approximately 12:30 PM, review of Resident #4's Nursing Progress Notes revealed that on November 10, 2007, 8:30 AM, a nurse wrote the following: "slight pink area on right hand. No pain noted. Area cleaned with normal saline...PCP made aware." Subsequent review of the Staff Daily Progress Notes in Resident #4's record revealed nothing unusual was documented on November 9, 2007. There was no daily progress note for the morning of November 10, 2007. At 1:08 PM, the "day nurse" was asked about the nurse's progress note and she stated that she was previously unaware of any "pink areas" discovered on Resident #4. She did, however, state that the resident had received a flu shot on November 9, 2007. Initially, this was being treated as if it were an	{I 291}	(1291) 3514.2 Resident Records This Statute will be met as evidenced by: Reference response to federal deficiency report W111 and W252.	12.13.07 ongoing

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{I 291}	Continued From page 5 injury of unknown origin. However, telephone interview with the LPN who had made the entry, at 1:16 PM, revealed that the nurse had indeed seen the pink area on the "upper arm, near the shoulder," where the flu shot had been administered. Further interview revealed that he had not been aware that the resident had received a flu shot on the day before. The flu shot, however, had been documented in the same Nursing Progress Notes, on November 9, 2007. During the aforementioned interviews, the day nurse indicated that the error of writing "right hand" instead of indicating the upper arm was a common error in certain immigrant populations. However, the Director of Nursing had stated over the telephone that the hand and upper arm "are too far apart to get confused." Further review of Resident #4's medical chart failed to show evidence that supervisory nursing staff had reviewed Resident #4's progress notes to ensure accuracy. 2. Nursing staff failed to update/ revise Resident #4's HMCP, to reflect a change in the resident's physical therapy programs and/or prescribed treatment for pain, as follows: a. On November 15, 2007, review of Resident #4's Health Management Care Plan (HMCP), dated September 24, 2007, revealed "potential for pain due to DJD," though not spelled out, DJD stands for degenerative joint disease. The HMCP indicated that staff were to provide the resident range of motion (ROM) exercises and to monitor for signs of pain. However, review of the resident's updated Individual Support Plan (ISP), dated October 5, 2007, revealed that his physical therapist and interdisciplinary team had changed	{I 291}		

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{I 291}	Continued From page 6	{I 291}		

the programs and the resident now was to ambulate around the home and dance for up to 3 minutes with staff instead of the ROM exercises. The HMCP had not been updated to reflect the new ISP objectives.

b. In addition, the HMCP failed to reflect the use of medication for treatment of joint pain. Resident #4's physician's orders (POs) dated June 1, 2007 included a handwritten notation dated May 1, 2007 for Tylenol 325 mg x 2 tabs was ordered as needed for pain or temperature greater than 100 degrees. On October 2, 2007, the resident was evaluated in a hospital ER after experiencing pain and swelling of his right thigh and foot. The ER discharge summary listed as primary diagnosis "arthritis - degenerative." The primary care physician's SOAP note dated October 4, 2007 did not reflect Tylenol for pain; however, his SOAP note dated October 13, 2007 included "P: Tylenol for joint pain." The October 13, 2007 SOAP note failed to specify the frequency/ parameters for administration of the Tylenol. The most recent physician's orders issued/ printed by the pharmacy, dated September 1, 2007, did not reflect Tylenol. Further review of the resident's medical record failed to clarify whether the October 13, 2007 SOAP note was a continuation of Tylenol on an as needed (PRN) basis or whether it represented a change to daily/ routine treatment order.

3. Facility staff failed to document in Resident #1's and #4's records curent/ observed behavioral data that was reflective of residents' performance, as follows:

a. On November 14, 2007, at approximately 7:00 AM, Resident #1 was observed displaying inappropriate behavior at the breakfast table.

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{I 291}	Continued From page 7 She screamed and tried to grab or strike Resident #6 with her hand. Resident #1 knocked over a mealtime protocol that was on the table. Direct support staff intervened and when the resident did not immediately calm down, they wheeled her into the living room area and away from the other residents. On November 16, 2007, at approximately 3:45 PM, review of the resident's behavior support plan (BSP), dated October 5, 2007, revealed that "screaming" and "reaching for/ grabbing others" were both targeted maladaptive behaviors. The BSP instructed staff to document every occurrence. Review of Resident #1's behavior data sheets a few minutes later, however, revealed that staff had not documented the observed behavioral incident in her record. b. On November 14, 2007, at 4:55 PM, Resident #4 was observed in the front foyer engaged in karaoke activities with direct support staff and the Qualified Mental Retardation Professional (QMRP). At approximately 5:00 PM, the QMRP presented an alphabet puzzle board to him, twice. He rejected the puzzle board and slapped his face a few times. He complied with the QMRP's request that he keep his hands away from his face. At approximately 5:30 PM, Resident #4 was observed in the front foyer with a direct support staff person. The resident was stimulating himself manually in his genital area. The staff person suggested that he move his hand away, and he complied. On November 16, 2007, at approximately 3:49 PM, review of Resident #4's BSP, dated August 19, 2007, revealed that "face slapping" and "public masturbation" were both targeted maladaptive behaviors. The BSP instructed staff to document every occurrence. Review of Resident #4's behavior data sheets a few minutes later,	{I 291}		

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{I 291}	Continued From page 8 however, revealed that staff had not documented the observed behavioral incident in his record. This is a repeat deficiency. See Federal Deficiency report dated October 5, 2007 - Citation W252.	{I 291}		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure nursing services in accordance with the needs of one of the six residents in the sample. (Resident #4) The findings include: 1. Nursing supervisors failed to provide ensure effective monitoring of Resident #4's flu shot area, for signs of potential adverse reactions/ side effects of the flu shot. Cross-refer to I291. On November 15, 2007, at approximately 12:30 PM, review of Resident #4's Nursing Progress Notes revealed that on November 10, 2007, 8:30 AM, a nurse wrote the following: "slight pink area on right hand. No pain noted. Area cleaned with normal saline...PCP made aware." At 1:08 PM, the "day nurse" stated that the resident had receive a flu shot on November 9, 2007.	I 401	1401 3520.3 This Statute will be met as evidenced by: Cross reference response to 1291.	12.18.07 ongoing

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I 401	Continued From page 9 Telephone interview with the LPN who had made the entry, at 1:16 PM, revealed that the nurse had seen the pink area on the "upper arm, near the shoulder." Further interview revealed that he had not been aware that the resident had received a flu shot on the day before. The flu shot, however, had been documented in the same Nursing Progress Notes, on November 9, 2007. 2. Nursing staff failed to update/ revise Resident #4's HMCP, to reflect a change in the resident's physical therapy programs. On November 15, 2007, at Review of Resident #4's Health Management Care Plan (HMCP), dated 9/24/07, revealed that the arthritis was not new. The HMCP included "potential for pain due to DJD." The HMCP indicated that staff were to provide the resident range of motion exercises and to monitor for signs of pain. However, review of the resident's updated Individual Support plan (ISP), dated October 5, 2007, revealed that his physical therapist and interdisciplinary team had changed the programs and the resident now was to ambulate around the home and dance for up to 3 minutes with staff instead. The HMCP had not been updated to reflect the new ISP objectives. In addition, the HMCP failed to reflect the order for Tylenol 650 MG for pain (PRN or otherwise). It should be noted that review of Resident #4's data sheets later that afternoon revealed that he had been refusing to ambulate or to dance since the beginning of October 2007. At approximately 3:30 PM, interviews with the QMRP, day nurse and the Director of Nursing revealed that direct support staff who were responsible for implementing the programs had not been trained on detecting signs or symptoms of joint pain.	I 401		

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I 422	Continued From page 10	I 422		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide habilitation, training and assistance in accordance with residents' Individual Support Plans (ISPs), for five of the six residents in the sample.. (Residents #1, #2, #3, #5 and #7) The findings include: 1. Cross-refer to Federal Deficiency Report - Citations W120 and W159. The GHMRP failed to monitor to ensure that day programs implemented Resident #2's and #5's mealtime protocols, as updated on October 15, 2007. 2. The facility failed to ensure that transfer sheets were purchased and/or used as recommended for Residents #3, #7 and #2. a. Resident #3 was observed seated in his wheelchair on November 14, 2007 at 8:52 AM. The review of Resident #3's physical therapy (PT) assessment, dated April 24, 2007, on November 16, 2007 at 2:37 PM revealed a transfer sling was recommended. Interview with direct care staff and observation on November 16, 2007 3:00 PM revealed the transfer sling was in the resident ' s bedroom. Interview with the QMRP at 3:15 PM indicated that the transfer sling should be placed underneath the resident when he is in his wheelchair. The resident was observed returning home from his day program at 3:40 PM on November 16, 2007 without his transfer sling in	I 422	(1422) 3521.3 Cross reference responses to federal Deficiency Report W120 and W159,	12.20.07 ongoing

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I 422	Continued From page 11 his wheelchair. b. On November 14, 2007 at 8:20 AM Resident #7 was observed seated in her wheelchair. The review of her PT assessment, dated June 16, 2007, revealed a recommendation to purchase a transfer sling. Observation and interview with staff on November 15, 2007 at approximately 2:50 PM revealed the transfer sling was in the resident's bedroom. Interview with the QMRP at 2:55 PM revealed the transfer sling should stay with the resident to ensure proper lifting. c. On November 14, 2007, at 6:43 PM, the QMRP and a certified nursing assistant were observed transferring Resident #2 from her wheelchair into a recliner in the living room. They had some difficulty getting the resident, whose records indicated was obese, through the process. On November 15, 2007, at 6:50 PM, the QMRP confirmed that there had been some difficulties in transferring the resident. She further indicated that Resident #2 was resistive to participating in the transfer process to any degree. At 7:02 PM, review of Resident #2's PT assessment, dated June 16, 2007, revealed a recommendation to purchase a "transfer sling" and a "wedge to use with repositioning while in bed." At 7:11 PM, observation of the resident's bed failed to show evidence of a wedge pillow and there was no transfer sling in the resident's wheelchair or in her bedroom. At that time, the QMRP acknowledged that neither the transfer sling nor the wedge pillow had been purchased to meet Resident #2's assessed needs. 3. The GHMRP failed to implement programs as outlined in Resident #2's Individual Program Plans (IPPs); as follows:	I 422		

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I 422	Continued From page 12 On November 14, 2007, a direct support staff person was observed feeding Resident #2 her dinner. After spooning approximately 5 spoonfuls of food, the staff took the resident's spout cup and 'dropped' a drop or two of water into the resident's mouth, before resuming with the feeding. She repeated the process again and throughout the meal. At no time was the staff observed to offer or encourage the resident to place her hand on the spout cup. On November 15, 2007, at 10:12 AM, review of the resident's IPP revealed a program for Resident #2 to "participate in bringing her cup to her mouth to drink when given hand over hand assistance..." Staff were not observed implementing the program as written during dinner on November 14, 2007. 4. Cross-refer to Federal Deficiency Report - Citation W436. The facility failed to ensure that adaptive equipment identified as needed by the interdisciplinary team were furnished and maintained for three of of the six clients residing in the facility. (Clients #1, #3, and #7) The findings include: a. The facility failed to ensure timely repair of Client #1's and #3's wheelchairs. b. The facility failed to furnish the recommended knee braces for Clients #3 and #7.	I 422		
(I 500)	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.	(I 500)	(1500) 3523.1 Residents Rights	

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IDI	4515 EDSON PLACE, NE WASHINGTON, DC 20019

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{I 500}	Continued From page 13 This Statute is not met as evidenced by: Based on observation, interview and record review, the facility to ensure the right to receive habilitation services and supports in accordance with identified needs, for five of the six residents in the sample. (Residents #1, #2, #3, #5 and #7) The findings include: 1. Cross-refer to Federal Deficiency Report - Citations W120 and W159. The GHMRP failed to monitor to ensure that day programs implemented Resident #2's and #5's mealtime protocols, as updated on October 15, 2007. 2. Cross-refer to I422.2. The facility failed to ensure that transfer sheets and/or wedge for repositioning were purchased and/or used as recommended for Residents #3, #7 and #2. 3. Cross-refer to Federal Deficiency Report - Citation W210. The facility failed to ensure that Resident #4 received an updated Occupational Therapy assessment, timely. 4. Cross-refer to Federal Deficiency Report - Citation W249. The facility failed to ensure that all staff were trained to effectively implement Resident #2's spout cup (hand-over-hand) training objective. 5. Cross-refer to Federal Deficiency Report - Citation W436. The facility failed to ensure timely repair of Client #1's and #3's wheelchairs and failed to furnish the recommended knee braces for Clients #3 and #7.	{I 500}	(1500) - continued... This Statute will be met as evidenced by: (1) Cross reference response to Federal Deficiency Report W120 and W159. (2) Cross reference response to I422.2 (3) Cross reference response response to Federal Deficiency Report W210. (4) Cross reference response to Federal Deficiency Report W249. (5) Cross reference response to Federal Deficiency Report W436.	12-21-07 ongoing